



Oregon

Theodore R. Kulongoski, Governor

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Bulletin No. 220 (Rev.) August 1, 2007

TO: Oregon Workers' Compensation Insurers and Self-Insured Employers

SUBJECT: Medical data reporting

This bulletin describes medical service billing data reporting requirements for workers' compensation insurers and self-insured employers (insurers) under Oregon Administrative Rules (OAR) 436-009-0030(10). These requirements apply to all insurers who had at least 100 accepted disabling claims in the previous calendar year as determined by the director. Any insurer may voluntarily submit medical service billing data in the prescribed format. This revision is to clarify that data sent electronically may only be sent in a secure format and not by e-mail or on diskette. No other substantive changes have been made. This bulletin replaces Bulletin 220 dated March 30, 2006. This will be the last Bulletin 220 published, as the information will be incorporated into the Division 009 rules.

The Department of Consumer and Business Services will notify insurers when they are required to submit medical service billing data. The list of affected insurers can be accessed from the Workers' Compensation Division's Web site:

www.cbs.state.or.us/external/wcd/communications/ins_list_medbilling.html. Insurers who have experienced a significant decrease in accepted disabling claims, below the threshold (100), may apply to the department in writing for exemption from these requirements if the decrease is expected to continue.

Insurers must submit data no later than 45 days after the end of each quarter, as shown below.

TABLE OF QUARTERLY DUE DATES

QUARTER	MONTH OF PAYMENT	DUE NEXT
First	January, February & March	May 15th
Second	April, May & June	August 14th
Third	July, August & September	November 14th
Fourth	October, November & December	February 14th

However, a grace period of two calendar quarters may be granted for revised requirements (found in boldface print) and also for insurers who are newly affected by these requirements. New and revised reporting must be complete for data with payment dates according to the Table above. Insurers granted a grace period are required to submit calendar year second and third quarter medical service billing data no later than November 14th.

MEDICAL DATA REPORTING REQUIREMENTS

Insurers are required to report information on all payments made during each quarter for medical services as defined in OAR 436-010-0005(27).

The department may use Bulletin 220 medical data for medical outcomes studies, identifying community standards and trends, cost analysis, and MCO/provider performance comparisons. Due to the potential use of this data in legislative and policy decision making, insurers are encouraged to strive for complete and accurate reporting, including the following codes: hospital revenue codes, ICD-9-CM, Physicians' Current Procedural Terminology (CPT®¹), HCPCS, NDC, anesthesiology, and optional data whenever available. Insurers are also encouraged to voluntarily submit data in the required format on medical payments for non-fee-schedule services such as ambulance and dental.

TECHNICAL REQUIREMENTS: Each quarter's data for the calendar year must be transmitted as an individual data file. Insurers transmitting data for more than one insurer may batch multiple insurer data files in one transmission. **Data must be transmitted in electronic text files by secure file transfer protocol (SFTP) using the secure shell (also known as SSH) protocol. Contact the Information Management Division to arrange submission of files by secure FTP.** The record length must be fixed, 129 bytes, no packed fields, and in conformance with the record layout on page 3 of this bulletin.

For each transmission, e-mail notification must be sent to the Information Management Division at Wcd.WcdMedicalData@state.or.us. The e-mail or an attached cover letter must include the following information: the name of the entity submitting the data, the quarter being reported, and the date the file was created; a list of all insurance companies whose data is reported in the transmission, the number of records; a contact person's name, address, and telephone number; and any known problems with the data.

DATA QUALITY: DCBS will conduct electronic edits for unnecessary blank or invalid data. Files which have more than five percent missing or invalid data in any field based on initial computerized edits will be returned for correction and must be resubmitted within 21 days from the date it was returned by the department.

AUDIT QUALITY: The director may also conduct field audits of actual payments reported for individual claims. When an audit occurs, to be in compliance with OAR 436-009-0025 and 436-009-0030, audited data must not have more than 15 percent inaccurate data in any field.

PENALTIES: Insurers that are not in compliance with OAR 436-009 may be subject to civil penalties under Oregon Revised Statutes 656.745.

Questions about medical data reporting are submitted to:

Department of Consumer & Business Services Information Management Division Research and Analysis Section 350 Winter St. NE PO Box 14480 Salem, OR 97309-0405 For technical information: (503) 378-8254 For policy and other related questions: (503) 947-7734
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SUMMARY OF CHANGES:

Clarification that data sent electronically must be sent in a secure format and may not be sent by e-mail or on diskette.

¹ CPT is a registered trademark of the American Medical Association.

RECORD LAYOUT FOR ELECTRONIC DATA TRANSMISSION

DESCRIPTION	ALPHA NUMERIC	POSITION	LENGTH	REQUIREMENT
Insurer's WCD number	9	1	4	Required
Insurer's claim number	X	5	20	Required
Claimant's SSN	9	25	9	Required
Date of injury (YYYYMMDD)	9	34	8	Required
Medical-only or disabling (MorD)	X	42	1	Optional
Medical provider-type	X	43	2	Required
Medical provider specialty	X	45	3	Required
Medical provider FEIN	X	48	10	Required
Medical provider other Federal Tax Reporting ID number or UPIN	X	58	9	Optional
MCO number	X	67	6	Required
ICD-9-CM diagnosis code	X	73	6	Required
Secondary ICD-9-CM diagnosis code	X	79	6	Optional
Service, drug, or procedure code	X	85	11	Required
Modifier code	X	96	2	Required
Date of service (YYYYMMDD)	9	98	8	Required
Date of payment (YYYYMMDD)	9	106	8	Required
Charge amount sign	X	114	1	Required
Charge amount	9	115	6	Required
Payment amount sign	X	121	1	Required
Payment amount	9	122	6	Required
Number of units or services	9	128	2	Required

RECORD LAYOUT SPECIAL FIELD REQUIREMENTS

DESCRIPTION	SPECIAL FIELD REQUIREMENTS
Alpha Numeric (Table Column)	X = Character or alphanumeric data: No lower-case letters; fill empty spaces with blanks and left-justify. 9 = Numeric data; right-justify numbers including leading zeros; fill empty spaces with zeros.
Length (Table Column)	No compressed or packed fields.
Insurer's WCD number	Workers' Compensation Division insurer number. National Association of Insurance Commissioners (NAIC) number, where applicable, is included for reference.
Date of injury (YYYYMMDD)	All dates in the form YYYYMMDD, for example, February 8, 2004 would appear as "20040208."
Medical provider-type	Use code from list of provider-type codes on Bulletin 220 page 6. For services with provider-type "MD", report the provider specialty code from the list on page 7.
Medical provider specialty	For services with provider-type "MD", report the provider specialty code from the list on Bulletin 220 page 7.
Medical provider FEIN	Use the federal employer identification number that is used for federal tax reporting purposes.
Medical provider other Federal Tax Reporting ID number or UPIN	Report the nine-digit other federal employer identification number that is used for federal tax reporting purposes, or the Unique Personal Identification Number of the individual providing the medical service.
MCO number	Report the MCO certification number if the claimant was enrolled (received notification to treat under MCO protocols) in a Managed Care Organization on or before the service date. Leave the field blank if the claimant was <u>not</u> enrolled at the time the service was provided.
ICD-9-CM diagnosis code	See Bulletin 220 instructions on page 5.
Secondary ICD-9-CM diagnosis code	See Bulletin 220 instructions on page 5.
Service, drug, or procedure code	See Bulletin 220 instructions on page 5.
Modifier code	See Bulletin 220 instructions on page 5.
Date of service (YYYYMMDD)	All dates in the form YYYYMMDD, for example, February 8, 2004 would appear as "20040208."
Date of payment (YYYYMMDD)	All dates in the form YYYYMMDD, for example, February 8, 2004 would appear as "20040208."
Charge amount sign	If this is a refund or other negative amount, put a minus-sign in this field, otherwise fill with a blank.
Charge amount	Rounded to the nearest whole dollar, for example, a \$300.05 payment would be shown as "000300."
Payment amount sign	If this is a refund or other negative amount, put a minus-sign in this field, otherwise fill with a blank.
Payment amount	Rounded to the nearest whole dollar, for example, a \$300.05 payment would be shown as "000300."
Number of units or services	See Bulletin 220 instructions on page 5.

DATA FIELDS SPECIAL REPORTING INSTRUCTIONS

UPIN: The unique provider identifier number (UPIN), is a six-position alphanumeric identifier that is assigned to all Medicare physicians, medical groups and non-physician practitioners. *Left-justify the UPIN and follow with blanks.*

ICD-9-CM DIAGNOSIS CODES: The International Classification of Diseases (ICD-9-CM) diagnosis code(s) must appear on all records where the provider-type is chiropractor, hospital inpatient, hospital outpatient, medical doctor, osteopath, physician's assistant, or registered nurse practitioner. See Table on page 6. The primary code must be supplied first and, if available, the secondary code should be supplied.

SERVICE, DRUG, OR PROCEDURE CODE: Report the Physicians' Current Procedural Terminology (CPT®) code or other applicable code from the Oregon Medical Fee and Relative Value Schedule (OMFARVS): for example, "99201". On payments for durable medical equipment, report the appropriate HCPCS code: for example, "E0110". On payments for pharmaceuticals, report the eleven-digit National Drug Code (NDC): for example, "61392054230". On hospital inpatient (HI) services, report the ICD-9-CM procedure code: for example, "81.97". If reporting a hospital outpatient service, you may report the appropriate hospital revenue code: for example, "450". *All codes must be left-justified and followed with blanks, as necessary, to comply with the required record layout format.*

SERVICE MODIFIER CODES:

- Submit bills from an ambulatory surgical center on a HCFA/CMS 1500 form. Use modifier 'SG' to identify ambulatory surgical center facility charges.
- Use modifier 'NT' (no time) on bills from a surgeon or attending physician administering a local or regional block for anesthesia during a procedure.
- Use modifier '50' when a surgical procedure is performed bilaterally for the second side.
- Use modifier '81' on bills for services by a physician assistant or nurse practitioner.
- Use a "zz" qualifier when billing electronically for services that use Oregon Specific Codes.

REPORTING ADJUSTMENT MODIFIER CODES: All adjustments to payments need to be associated with specific services. For a refund payment, repeat the record exactly as originally reported but enter payment and charge amounts as negatives (put minuses in the sign fields) and put "RF" (for refund) in the modifier code field. Adjustments that result in a partial refund or additional payment for a service that has already been paid should be coded with "DC" in the modifier code field.

NUMBER OF UNITS OR SERVICES: Report the number of time units paid on each time-based service such as anesthesiology and therapeutic procedures. For example, where base time unit equals 15 minutes (anesthesia, CPT® 97110, 97530, etc.), one hour of service equals "04" units. Where base time unit equals one hour (CPT® 97546), two hours of service equals "02" units. Also report the number of services if multiple, identical services to a patient are bundled into one record. For example, three whirlpool treatments (CPT® 97022) equals "03".

MEDICAL PROVIDER TYPES: Use the following codes to describe the type of medical provider:

TABLE OF MEDICAL PROVIDER-TYPE CODES

PROVIDER DESCRIPTION	CODE
Acupuncturist	AC
Ambulatory Surgical Center	AS
Chiropractor	CH ₁
Dentist	DE
Home Health Care	HH
Hospital inpatient	HI ₁
Hospital outpatient	HO ₁
Laboratory	LA
Medical Doctor	MD ₁
Medical supplies	MS
Naturopath	NA
Nursing Home	NH
Occupational Therapist	OT
Optometrist	OP
Osteopath	OS ₁
Pharmacy	PH
Physical Therapist	PT
Physician's Assistant	PA ₁
Podiatrist	PO
Psychologist	PS
Radiologist	RA
Registered Nurse Practitioner	NP ₁
Other Medical Provider	OM

1. ICD-9-CM diagnosis codes are required on records with these types.

PROVIDER TYPE SPECIAL REPORTING INSTRUCTIONS

HOSPITAL INPATIENT: Each hospital inpatient stay should be reported as one record, which summarizes all services related to the inpatient stay using provider-type "HI." Physicians' Current Procedural Terminology (CPT®) or other single-service codes should not appear on these summary records. Instead, report the ICD-9-CM procedure code in the service code field.

HOSPITAL OUTPATIENT: Outpatient services should be reported at the individual service-code level using provider type "HO." A service code is required on all "HO" records. ICD-9-CM diagnostic codes are required on all hospital outpatient records. Payments to hospitals for outpatient physical therapy procedures or modalities must be reported at the CPT® level in the same manner as they would be if received from a private practitioner or physical therapy clinic, except that provider-type "HO" applies. This same requirement applies to emergency room services, radiology, and ambulatory surgical center services for non-admitted patients.

PHYSICIAN ASSISTANT or NURSE PRACTITIONER: The bills for services by these providers must include the modifier '81'.

MEDICAL PROVIDER SPECIALTY: If the medical provider-type is "MD", use the following codes to designate the medical provider specialty:

TABLE OF MEDICAL PROVIDER SPECIALTY CODES

PROVIDER SPECIALTY	CODE
Anesthesiologist	ANE
Dermatologist	DER
Emergency medicine	EMM
Family practice	FPR
General practice	GPR
General surgeon	GSU
Internist ₃	INT
Neurologist	NEU
Neurosurgeon	NSU
Occupational medicine	OCC
Ophthalmologist	OPH
Oral surgeon	OSU
Orthopedist/Orthopedic surgeon	ORS
Otolaryngologist	OTO
Pathologist	PTH
Physiatrist	PMR
Plastic surgeon	PSU
Psychiatrist	PSY
Radiologist	RAD
Urologist	URO
Other surgical/non-surgical specialists ₁	OTH
Unknown specialist ₂	UNK

1. Indicates provider specialty does not fit any of the above categories.
2. Indicates provider specialty cannot be determined.
3. All internal medicine specialties.

/s/ John L. Shilts

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 Workers' Compensation Division

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